STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155166	B. WIN	G		05/15/	2012
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
VALPAR	AISO CARE AND	REHABILITATION CENTER		606 WA	RAISO, IN 46383		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	This visit was for State Licensure included the Invitation IN00108232. Complaint IN00 Federal/State deallegations are of the state of	or a Recertification and Survey. This visit vestigation of Complaint 20108232: Substantiated, efficiencies related to the cited at F157 and F314. May 7, 8, 9, 10, 11, and 15, T: 000083 er: 155166 100289670 N-TC , RN and 15, 2012) e, RN , RN szewski, RN 0, and 11, 2012)	F00		The creation and submission this Plan of Correction does no constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation a requests a post survey revisit or after June 7, 2012.	ot s : n of f	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

005011

Facility ID:

000083

TITLE

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 05/15/2012					
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
TAG	Medicaid: 116 Other: 15 Total: 146 Sample: 24 Supplemental sa These deficience cited in accordance	mple: 5 es reflect state findings nce with 410 IAC 16.2. completed on May 18,	TAG	DEFICIENCY		DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 005011

Facility ID: 000083

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	DDIG	00	COMPL	ETED
		155166	A. BUIL			05/15/	2012
			B. WIN		DDDFGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	4			ADDRESS, CITY, STATE, ZIP CODE		
\/AL DAD		SELIADII ITATIONI CENTED	606 WALL ST				
VALPARA	AISO CARE AND R	EHABILITATION CENTER		VALPAI	RAISO, IN 46383		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CHA						
	(INJURY/DECLIN						
		mediately inform the					
		with the resident's					
		known, notify the resident's					
		ve or an interested family					
		ere is an accident involving h results in injury and has					
		equiring physician					
	•	gnificant change in the					
		al, mental, or psychosocial					
		erioration in health, mental,					
	or psychosocial s						
	threatening condi						
	complications); a	need to alter treatment					
		a need to discontinue an					
	•	reatment due to adverse					
		r to commence a new form					
	·	a decision to transfer or					
	•	ident from the facility as					
	specified in §483.	.12(a).					
	The facility must a	also promptly notify the					
		nown, the resident's legal					
		interested family member					
	when there is a cl	-					
		ment as specified in					
	_	a change in resident rights					
		State law or regulations as					
	specified in parag	graph (b)(1) of this section.					
		record and periodically					
		ss and phone number of					
		al representative or					
	interested family		EO1	57			06/07/2012
		review and interview, the	F01:	3/	F157 NOTIFY OF CHANGES		06/07/2012
	facility failed to notify a resident's physician of a pressure area that had				(INJURY/DECLINE/ROOM, ETC)		
					A facility must immediately info	orm	
	reopened on the	resident's great right toe			the resident; consult with the		
	-	ents reviewed for			resident's physician; and if		
	101 1 01 2 1 100100	101101104101					

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Event ID: 005011

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If continuation sheet Page 3 of 54

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		LDING	00	COMPLETED
		155166	B. WIN			05/15/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			606 WA		
		EHABILITATION CENTER			RAISO, IN 46383	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	physicians' notifi	ication in a sample of 24.			known, notify the resident's leg	
	(Resident B)				representative or an interested	
	,				family member when there is a	
	Findings include				accident involving the resident	
	Findings include	•			which results in injury and has	
					potential for requiring physicia	
	Resident B's reco	ord was reviewed on			intervention; a significant char in the resident's physical, men	_
	5/7/12 at 1:15 p.1	m. Resident B's			or psychosocial status (i.e., a	itai,
	diagnoses includ	ed, but were not limited			deterioration in health, mental	. or
		itus, anemia, and multiple			psychosocial status in either li	
	sclerosis.	itus, unemia, una marapie			threatening conditions or clinic	
	SCICIOSIS.				complications); a need to alter	ſ
					treatment significantly (i.e., a	
	-	ated 4/17/12 at 2:59 p.m.,			need to discontinue an existing	g
	indicated the ope	en area to the resident's			form of treatment due to adve	
	right great toe ha	d resolved. The nurses'			consequences, or to commend	ce a
	note indicated th	e resident's physician had			new form of treatment); or a	
		d a new order had been			decision to transfer or discharge	
		ontinue the treatment to			the resident from the facility as specified in 483.12(a).	
					specified in 465.12(a).	
	the Resident's to	e.			The facility must also promptly notify	/ the
					resident and, if known, the resident's	s
	A nurses' note, d	ated 4/21/12 at 4:16 p.m.,			legal representative or interested far	mily
	indicated the righ	nt great toe was open and			member when there is a change in room or roommate assignment as	
	pink.				specified in §483.15(e)(2); or a chan	nge
	F				in resident rights under Federal or S	tate
	Thomas - 1 - 1	of documentation in the			law or	
		of documentation in the			regulations as specified in	n
		to indicate the resident's			paragraph (b)(1) of this section The facility must record and	11.
	physician was no	otified of the resident's			periodically update the addres	ss
	great right toe re	-opening.			and phone number of the	~
					resident's legal representative	or
	An interview on	5/8/12 at 10:05 a.m., the			interested family member.	
					What corrective action(s) wil	I
	Wound Nurse indicated the nurse had not notified Resident B's physician when the				be accomplished for those	
					residents found to have beer	n
		right toe had reopened on			affected by the deficient	
	4/21/12.				practice	

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Event ID: 005011

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If continuation sheet Page 4 of 54

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
NAME OF PROVIDER OR SUPPLIER VALPARAISO, CARE AND REHABILITATION CENTER VALPARAISO, IN 46383 SIMMARY STATIMINT OF DELICIBACIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG This Federal tag relates to complaint IN00108232. 3.1-5(a)(3) This Federal tag relates to complaint IN00108232. 3.1-5(a)(3) This Federal tag relates to complaint Involution of the same deficient practice and what corrective actions yield believe wound clinic visit. Her primary physician and her physician at the wound clinic are the same deficient practice and what corrective action will be taken - A skin sweep was completed and residents physicians were notified of any abnormal findings All residents have the potential to be affected by the same deficient practice. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur - Nursing staff will be educated on Physician Tamily Notification by the SDC/designee by 5/29/12 Noncompliance with facility policy and procedure may result in employee re-education and/or disciplinary action up to and including termination. The Physician Telephone Orders and for condition is reported to the	AND PLAN	OF CORRECTION		A. BUILDING	00	
NAME OF RECOVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER VALPARAISO, IN 46383 VALPARAISO, IN			155166	B. WING		05/15/2012
VALPARAISO CARE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MLST BE PRECEDED BY FULL TAG REGULATORY OR LSC DENTIFYTING INFORMATION) This Federal tag relates to complaint IN00108232. 3.1-5(a)(3) **Resident B's physician was notified on April 27, 2012 during a wound clinic visit. Her primary physician and her physician at the wound clinic are the same deficient practice and what corrective action will be taken or residents having the potential to be affected by the same deficient practice and what corrective action will be taken or what systemic changes you will make to ensure residents have the potential to be affected by the alleged deficient practice. What measures will be put into place or what systemic changes you will make to ensure residents physician family Notification by the SDC/designe by 5/28/12. **Noncompliance with facility policy and procedure may result in employee re-education and/or disciplinary action up to and including termination. The Physician Telephone Orders and the 24 Hour Report sheets are audited by the Unit Managers and/or designee to ensure resident change to the sure resident change to the unit managers and/or designee to ensure resident change to the unit managers and/or designee to the sure resident change of condition is reported to the	NAME OF P	PROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
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					physician, physician orders are	e

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPL	ETED
		155166	B. WING		05/15/	/2012
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
				followed through timely a plans are updated daily. How the corrective action		
				will be monitored to ens deficient practice will no i.e., what quality assura program will be put into	sure the ot recur, nce	
				The Unit Managers complete a "Change of C CQI tool daily x 4 weeks, 8 weeks and monthly one thereafter to monitor family physician notification compliance. The audits are review.	ondition" weekly x going ily and	
				the CQI committee and a plans are developed to in performance, which may education, skills validatio performance improvement and/or disciplinary action	nprove include ns, nt,	

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Event ID: 005011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE			ETED	
		155166	B. WIN			05/15/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			606 WA			
VAI PAR	AISO CARE AND R	EHABILITATION CENTER			RAISO, IN 46383		
			1		T	1	(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
F0223		· · · · · · · · · · · · · · · · · · ·	+	TAG	BEI ICIERCI (DATE
SS=D		USE/INVOLUNTARY					
	SECLUSION	the right to be free from					
		the right to be free from sysical, and mental abuse,					
	•	ent, and involuntary					
	seclusion.	one, and involuntary					
	The facility must i	not use verbal, mental,					
		al abuse, corporal					
	-	voluntary seclusion.					
		ation, interview, and	F02	23			06/07/2012
	record review, th	ne facility failed to ensure			F223 FREE FROM ABUSE/INVOLUNTARY		
	a resident was from	ee from verbal abuse			SECLUSION		
	related to a CNA	yelling at a resident,					
		observation of 1 resident			The resident has the right to be free		
	•	or abuse in a total sample			from verbal, sexual, physical, and mental abuse, corporal punishment,	and	
	of 24. (Resident	•			involuntary seclusion. The facility mu		
	or 24. (Resident				not use verbal, mental, sexual, or		
	D: 1: : 1 1				physical abuse, corporal punishment	t, or	
	Findings include				involuntary seclusion.		
	Resident C's reco	ord was reviewed on			What corrective action(s) will	Į	
		0 a.m. The resident's			be accomplished for those		
		ed, but were not limited			residents found to have been	1	
	· ·	a, seizure disorder,			affected by the deficient practice		
	•				practice		
	malnutrition, res	•			C.N.A. #1 was suspende	ed	
		x, shortness of breath,			pending the outcome of the	•	
		s, and congestive heart			investigation. Resident #C wa	S	
	failure.				interviewed by the Unit Manag		
					immediately following the repo		
	A Quarterly Min	imum Data Set (MDS)			by the ISDH surveyor regarding the incident.	9	
	Assessment, date	ed 4/28/2012, indicated			the incident. The allegation was		
		gnition was intact.			investigated and found to be		
					unsubstantiated and the reside	ent	
	On 5/8/12 at 2:4	5 p.m., upon entering the			denies any feelings of abuse of	or	
					neglect.		
	resident s room,	CNA #1 was overheard					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155166	B. WIN			05/15/2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		606 WA		
\/AI DAD	AISO CADE AND E	REHABILITATION CENTER			RAISO, IN 46383	
VALFAR	AISO CARE AIND P	REHABILITATION CENTER		VALFA	KAISO, IN 40303	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG				TAG	DEFICIENCY)	DATE
	stating to the res	sident in a loud tone of			How will you identify other	
	voice "put you o	on fluid restriction" and			residents having the potentia	al
		e like I am crazy."			to be affected by the same	
	Don't talk to m	o mile i um eruzy.			deficient practice and what	
	D	i ith Danidant Cat			corrective action will be take	n
	_	view with Resident C, at			All registerate that live in	4h a
	•	esident was tearful. The			 All residents that live in facility have the potential to be 	
		ed CNA #1 was upset			affected by the alleged deficie	
	because she had	a "boo boo" (verified			practice.	
	with resident that boo boo meant bowel				All staff will be educated	d by
	movement). She	e indicated CNA #1 took			the Director of Nursing	
	her coffee and d	umped it out when she			Services/designee on the Abu	
	wasn't done and told her that she was				Policy and Reporting by 5/29/	12.
		on a fluid restriction.				
					\A/\cd	4-
		cated CNA #1 was not			What measures will be put in	το
		ob and shouldn't take it			place or what systemic changes you will make to	
	out on her. She	also indicated that this			ensure that the deficient practi	ce l
	was not the first	time CNA #1 had yelled			does not recur	
	at her and did no	ot want her to take care of				
	her anymore.				· All staff will be inservice	d
	,				monthly on the Abuse Policy a	t
	The Administrat	tor was notified of CNA			the all staff meeting by the	
					SDC/designee ongoing.	
	-	resident on 5/8/12 at 2:45			During Customer Care	well
	p.m.				rounds (Monday – Friday), as as nursing rounds per shift dai	
	2.1.27(.)(1)				all residents will be interviewed	
	3.1-27(a)(1)				regarding any concerns regard	
	3.1-27(b)				resident's rights and abuse.	
					Findings will be documented	on
					the Daily Rounds Checklist an	d
					the Customer Care Rounds	
					Sheets and be addressed	
					immediately.	
					 The Daily Rounds Checklists and Customer Care 	
					Rounds Sheets will be reviewed	
					during daily meetings by the	
					ED/designee for compliance.	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/15/2012	
	PROVIDER OR SUPPLIE		606 W	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				How the corrective action(s) we be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place The DNS/designee will complete an "Abuse Prohibition and Investigation" CQI tool will utilized weekly x 4, then month ongoing thereafter. Data will be submitted to the CQI Committee for review and follow up. Action plans will be developed needed for issues identified to improve compliance.	n I be nly 0

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	COMPLETED			
		155166	B. WING		05/15/2012		
				ADDRESS, CITY, STATE, ZIP CODE	l		
NAME OF F	PROVIDER OR SUPPLIE	R					
\/AI DAD	VALPARAISO CARE AND REHABILITATION CENTER			606 WALL ST VALPARAISO, IN 46383			
	AISO CARE AND I	REHABILITATION CENTER	VALE				
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
F0226 SS=D	ETC POLICIES The facility must written policies a	MENT ABUSE/NEGLECT, develop and implement and procedures that prohibit					
	residents and mi property.	eglect, and abuse of isappropriation of resident					
	record review, t the facility's pol was free from v CNA yelling at	,	F0226	F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIE The facility must develop and implet written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropris of resident property. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	ment ation		
	o5/08/12 at 10:0 diagnoses inclus schizophrenia, si malnutrition, recirculatory shoot diabetes melliture. A Quarterly Min Assessment, day the resident's comparation of the resident's room, stating to the resident stating stating stating stating stating to the resident stating	cord was reviewed on 20 a.m. The resident's ded, but are not limited to seizure disorder, spiratory failure, sk, shortness of breath, ss, and congestive heart nimum Data Set (MDS) ted 4/28/2012, indicated ognition was intact. 45 p.m., upon entering the CNA #1 was overheard sident in a loud tone of on fluid restriction" and		practice C.N.A. #1 was suspend pending the outcome of the investigation. Resident #C was interviewed by the Unit Managimmediately following the report by the ISDH surveyor regarding the incident. The allegation was investigated and found to be unsubstantiated and the resid denies any feelings of abuse of neglect. How will you identify other residents having the potentiate to be affected by the same deficient practice and what corrective action will be taked. All residents have the potential to be affected by the same deficient to be affected by the same deficient practice and what corrective action will be taked.	ent or		

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Event ID: 005011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		155166	B. WIN	IG		05/15/2	2012
NAME OF I	DROVIDED OD GUDDU IER		_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	C.		606 WA	ALL ST		
VALPAR	AISO CARE AND R	REHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SHO			COMPLETION
TAG	`			TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		e like I am crazy."			alleged deficient practice.	1	
	Don't talk to lik	tinke i am erazy.			All staff will be educated	by	
	D : .,	· · · · · · · · · · · · · · · · · · ·			the Director of Nursing	,	
		iew with Resident C, at			Services/designee on the Abu	se	
	_	sident was tearful. The			Policy and Reporting by 5/29/	12.	
		ed CNA #1 was upset			347 / 37 /		
	because she had	a "boo boo" (verified			What measures will be put into		
	with resident that	t boo boo meant bowel			place or what systemic change you will make to ensure that the		
	movement). She	e indicated CNA #1 took			deficient practice does not rec		
	· · · · · · · · · · · · · · · · · · ·	umped it out when she					
wasn't done and told her that she was going to put her on a fluid restriction. Resident C indicated CNA #1 was not					· All staff will be inservice	d	
					monthly on the Abuse Policy a	ıt	
					the all staff meeting by the		
					SDC/designee ongoing.		
	1 111	ob and shouldn't take it			During Customer Care Triday), as	الميد	
	out on her. She	also indicated that this			rounds (Monday – Friday), as as nursing rounds per shift da		
	was not the first	time CNA #1 had yelled			all residents will be interviewed		
	at her and she di	d not want her to take			regarding any concerns regard		
	care of her anym	nore.			resident's rights and abuse.		
					Findings will be documented		
	The Administrat	or was notified of CNA			the Daily Rounds Checklist an	d	
		resident on 5/8/12 at 2:45			addressed immediately.		
	'	1651dent on 3/6/12 at 2.43			 The Daily Rounds Checklists will be reviewed du 	ring	
	p.m.				daily meetings by the	illig	
	.	5/0/10 + 0.45			ED/designee for compliance.		
		vation on 5/8/12 at 2:45					
	_	Init Manager was			How the corrective action(s) w	ill	
	observed taking	CNA #1 to her office and			be monitored to ensure the		
	then walked the	CNA out of the building.			deficient practice will not recui	,	
					i.e., what quality assurance		
	According to the	e facility policy titled,			program will be put into place		
	"Abuse Prohibition, Reporting, and Investigation," dated February 2010, received from the Administrator as current indicated "It is the policy of				The DNS/designee will complete	_{ete}	
					an "Abuse Prohibition and		
					Investigation"		
					· CQI tool will be utilized		
		r Communities to protect			weekly x 4, then monthly ongo	ing	
		•			thereafter.	_	
	residents from a	buse including physical			Data will be submitted to	٥	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER: 155166	A. BUILDING B. WING	COMPLETED 05/15/2012
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	abuse, sexual abuse, verbal abuse, mental abuse, neglect, involuntary seclusion, and misappropriation of resident property and/or fundsVerbal Abuse is defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples would include, but are not limited to: threats of harm, saying things to frighten a resident, such as telling a resident that he/she will never be able to see his/her family member again; or scolding and/or speaking to them in harsh voice tonesMental Abuse-includes, but is not limited to, humiliation, harassment, threats of punishment, or deprivation" 3.1-28(a)	the CQI Committee for revier and follow up. Action plans will be developed as needed for iss identified to improve compliants.	w

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155166	B. WING		05/15/2012
NAME OF P	PROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	
VALPAR		REHABILITATION CENTER	606 WALPA	ALL ST RAISO, IN 46383	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE

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the facility failed to ensure residents' care plans were developed and updated, related to, activities, medications, pressure ulcers, urinary incontinence, and vision for 4 of 24 residents reviewed for care plans in a total sample of 24. (Residents #30, #59, #78, and #130) Findings include: PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
NAME OF PROVIDER OR SUPPLIER VALPARAISO CARE AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL. TAG REGULATORY OR LS CURSTRIVEN SINFOLOR SUPPLIES COMMERTION (COMPLETION SINGLE) FO280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's family or the resident, the resident's family or the resident, and other appropriate staff in disciplines as determined by the resident's family or the resident, the resident's family or the resident, and other appropriate staff in disciplines as determined by the resident's family or the resident, and other appropriate staff in disciplines as determined by the resident's family or the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the residents legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review, and interview, the facility failed to ensure residents' care plans were developed and updated, related to, activities, medications, pressure ulcers, urinary incontinence, and vision for 4 of 24 residents reviewed for care plans in a total sample of 24. (Residents #30, #59, #78, and #130) Findings include: A comprehensive care plan must be			155166				05/15/	2012
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION) FO280 SS=E REGILATORY OR LSC IDENTIFYING INFORMATION) FO280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident, the resident's ready and, to the extent practicable, the participation of the resident, the resident's ready and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review, and interview, the facility failed to ensure residents' care plans were developed and updated, related to, activities, medications, pressure ulcers, urinary incontinence, and vision for 4 of 24 residents reviewed for care plans in a total sample of 24. (Residents #30, #59, #78, and #130) Fo280 Fo280 Fo280 Fo280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment or changes in care and treatment. A comprehensive care plan must be					606 WA	ALL ST		
FO280 483.20(4)(3), 483.10(k)(2) RIGHTTO PARTICIPATE PLANNING CARE.REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review, and interview, the facility failed to ensure residents' care plans were developed and updated, related to, activities, medications, pressure ulcers, urinary incontinence, and vision for 4 of 24 residents reviewed for care plans in a total sample of 24. (Residents #30, #59, #78, and #130) Findings include: A comprehensive care plan must be	` '					(EACH CORRECTIVE ACTION SHOULD BE	ΓE	
RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review, and interview, the facility failed to ensure residents' care plans were developed and updated, related to, activities, medications, pressure ulcers, urinary incontinence, and vision for 4 of 24 residents reviewed for care plans in a total sample of 24. (Residents #30, #59, #78, and #130) Findings include: Findings include: Findings include:		REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
1. Resident #30's record was reviewed on 5/9/12 at 9:52 a.m. Resident #30's diagnoses included, but were not limited to, senile dementia, depression, and by most appropriate staff in disciplines as determined by the resident's needs,		RIGHT TO PART CARE-REVISE Control The resident has incompetent or of incapacitated uncomparticipate in plan changes in care at the A comprehensive developed within of the comprehen by an interdiscipling the attending phy with responsibility appropriate staff in by the resident's practicable, the puther resident's family representative; and revised by an after each assess Based on record the facility failed plans were developed related to, activity pressure ulcers, wision for 4 of 24 care plans in a to (Residents #30, #Findings include 1. Resident #30' 5/9/12 at 9:52 and diagnoses include 1.	the right, unless adjudged therwise found to be are the laws of the State, to ming care and treatment or and treatment. The care plan must be and treatment or and treatment. The care plan must be are the completion asive assessment; prepared the nary team, that includes sician, a registered nurse of for the resident, and other in disciplines as determined the eds, and, to the extent articipation of the resident, and periodically reviewed team of qualified persons sment. The review, and interview, are to ensure residents' care to ensure residents' care to ensure residents, arrinary incontinence, and are sidents reviewed for the tall sample of 24. The state of the state of the tall sample of 24. The state of the state of the tall sample of 24. The state of the state of the tall sample of 24. The state of the state, to minimize the state of the st	F02	80	The resident has the right, unleadjudged incompetent or otherwise foun be incapacitated under the laws of the State, to participate in planning care and treatment of changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nur with responsibility for the resident, an other appropriate staff in disciplines.	d to of r t. he se nd	06/07/2012

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155166	B. WIN			05/15/2012	
NAME OF PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
				606 WA			
VALPAR	AISO CARE AND F	REHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	· ·	DATE	
					participation of the resident, the resident's family or the reside	 	
	A CAA (Care A				legal representative; and	111.5	
	Summary), date	d 3/28/12, indicated the			periodically reviewed		
	resident would be	be care planned for the			and revised by a team of qual	ified	
	problem areas o	f activities and urinary			persons after each assessme	nt	
	incontinence.						
					What corrective action(s) wi	п	
		lent #30's care plans,			be accomplished for those		
	dated 4/18/12, ii	ndicated a lack of			residents found to have bee	n	
	documentation of	of care plans for the			affected by the deficient		
	problem areas o	f activities and urinary			practice		
	incontinence.				· The care plans for Residents #30, #59, #78 and		
					#130 have been reviewed an		
	An interview on	5/9/12 at 11:00 a.m., the			updated as indicated.		
	East Unit Mana	ger indicated there were			_		
		the resident's record for			How will you identify other		
	_	inary incontinence.			residents having the potential		
					be affected by the same defice practice and what corrective	ient	
	2 Resident #59	's record was reviewed on			action will be taken		
		a.m. Resident #59's					
		ded, but were not limited			· Residents residing in the	 	
	to, depression a				facility have the potential to be		
	to, depression a	nd my percension.			affected by the alleged deficient practice.	71 IL	
	A CAA summa	ry, dated 4/16/12,			· All resident care plans		
		cility would proceed to			have been reviewed for accur	- 1	
		e problem area of vision.			The Interdisciplinary Te	eam	
	care plan for the	problem area of vision.			will be re-educated by the DNS/designee on individualiz	ed	
	Danie Cul				care plan completion by 5/29/		
		esident's care plans, dated					
	· ·	documentation of a care			What measures will be put int		
	1 ^	olem area of the resident's			place or what systemic chang		
	vision.				you will make to ensure that the	 	
					deficient practice does not rec	Jui	
		5/11/12 at 8:50 a.m., the			Residents care plans w	vill	
	East Unit Mana	ger, indicated Social			be developed upon admission		

	OF CORRECTION OF CORRECTION 155166	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/15/2012
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Services had assessed the resident for vision and the resident had trouble reading small print. The East Unit Manager indicated the resident had not been care planned for the problem area of vision. 3. Resident #78's record was reviewed on 05/9/12 at 10:35 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. A Significant Change MDS Assessment,		annually and with significant change and reviewed at least quarterly by the IDT and updar as needed. The care plan will be completed as indicated based the issues identified with the completion of the comprehens MDS/CAA process. The care plan meeting guideline form will be utilized to ensure triggered CAAS requiring a care plan will have care plan in place. The DNS is responsible ensure resident's plan of care an accurate reflection of residenceds. How the corrective action(s) who be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place DNS/designee will complete a "Care Plan" CQI to will be utilized weekly x 4, ther monthly ongoing thereafter. Data will be submitted to the CQI Committee for review. An action plan may be develop for identified issues.	on sive Dy ee a to is ents vill

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMPI - 05/15	
	PROVIDER OR SUPPLIER		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CO LL ST RAISO, IN 46383	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
		ndicated the resident was tinent of urine and was a area.					
	Care Area Asses 01/24/12, indicat to proceed with a incontinency and There was a lack indicate a care plant.	ange MDS Assessment sment (CAA), dated ted the facility was going a care plan for drisk for pressure areas. To f documentation to lan had been initiated for ence and pressure ulcer					
	a.m., MDS Nurs no care plan initi	iew on 05/09/12 at 11:50 e #3 indicated there was lated for urinary I pressure ulcer risk.					
	on 05/08/12 at 1 diagnoses includ	O's record was reviewed 15 p.m. The resident's ed, but were not limited ratory failure and					
	05/12, indicated (blood thinner) 4	ecapitulation Order, dated an order for Lovenox 0 mg (milligrams).					
	documentation a	lated 4/13/12, lacked care plan for Lovenox d for the resident.					

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		IDENTIFICATION NUMBER: 155166	A. BUILDING B. WING	00	COMPLETED 05/15/2012	
		EHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
TAG	During an intervi	iew on 05/09/12 at 11:50 e #3 indicated there was	TAG	DEFICIENCY)	DATE	
				1		

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPLETED	
		155166	B. WIN			05/15/2012	
			B. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER						
\/AL DAD	ALOO OADE AND D	ELIADU ITATION CENTED		606 WA			
VALPARA	AISO CARE AND R	EHABILITATION CENTER		VALPAI	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
F0282 SS=E	483.20(k)(3)(ii) SERVICES BY Q CARE PLAN	UALIFIED PERSONS/PER					
	The services prov facility must be pr	vided or arranged by the rovided by qualified					
	persons in accord written plan of car	dance with each resident's re.					
			F02	82	F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	06/07/2012	
		review and interview, the			The services provided or		
		ensure residents received			arranged by the facility must be		
	medications as o	rdered by the physician			provided by qualified persons i		
	for 2 of 24 reside	ents reviewed for			accordance with each resident	.'s	
	following physic	ian's orders in a total			written plan of care.		
		Residents #62 and C)			What corrective action(s) will		
	Sample of 24. (I	residents #02 and C)			be accomplished for those		
	Findings include	:			residents found to have been affected by the deficient	1	
	C				practice		
					· Resident #C is receiving	g	
					medications as ordered.		
					· Resident #62 is receivin	g	
					medications as ordered.		
					How will you identify other	.	
					residents having the potentia	N.	
					to be affected by the same		
					deficient practice and what		
					corrective action will be take	n	
					· Residents with physicial		
					orders have the potential to be		
					affected by the alleged deficient practice.	п	
					Fractice. Licensed nurses will be		
					re-educated on following		
					physician orders by the		
					DNS/designee by 5/29/12.		
					· DNS/designee have		
					audited all resident physician		
			1		orders to ensure that all		

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	F OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 05/15/2012
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	606 W	ADDRESS, CITY, STATE, ZIP CODE ALL ST .RAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
				physicians' orders are being followed.	g
				What measures will be purplace or what systemic changes you will make to ensure that the deficient practice does not recur	t into
				The Interdisciplinary reviews the physician order the clinical meeting (Mon-F DNS/designee will assign a license nurse to review the medication administration record to ensure medications have administered per physician orders. The Unit Managers/designee will aud MAR/TAR's to ensure physorders are followed (Mon-F The "MAR/TAR" CQI tool wutilized weekly x 4, then moongoing thereafter.	rs at ri). ds daily e been dit the ician's ri).
				How the corrective action will be monitored to ensure deficient practice will not i.e., what quality assurance program will be put into possible. The SDC/designee we complete a "Medication Administration" CQI tool will utilized weekly x 4, then monogoing thereafter. Data will be submitted the CQI Committee for revisand follow up.	re the recur, ee lace vill li be onthly

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MU A. BUII B. WIN	DING	onstruction 00	(X3) DATE COMPI 05/15	ETED
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET A	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	5/09/12 at 9:00 a diagnoses includ to, diabetes mell seizure disorder, failure, circulato breath, and cong Resident C's phy 3/27/12 at 2:00 p (discontinue) ommedicine) 20 mg day) per peg-tub mg QD per peg to The MAR (Medi Record), dated 3 omeprazole 30 n 3/28/12. The Mato indicate the or been given between the Nurses' Note 3/27/12 at 2:34 propersion of the Nurses' Note 3/28/12 at 11:37	ication Administration /12, indicated the ng order was to begin on AR lacked documentation meprazole 30 mg had een 3/28/12 to 3/31/12.			Noncompliance with a procedures may result in disciplinary action.	acility	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPI	LETED
	155166	B. WING			/2012
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	The MAR, dated 4/12, indicated the resident received the 20 milligrams of omeprazole on 4/1/12 through 4/16/12.				
	During an interview with the DoN (Director of Nursing) and the West Unit Manager on 5/09/12 at 11:55 a.m., the DoN and West Unit Manager indicated the dosage was not correct on the MAR and the resident continued to receive omeprazole 20 mg daily. 2. Resident #62's record was reviewed on 5/8/12 at 1:25 p.m., Resident #62's diagnoses included, but were not limited to, below knee amputation, hypercholesterolemia (high cholesterol), and hypertension. Resident #62's admission physician's orders, dated 4/21/12, from the hospital, indicated "aspirin 325 MG (milligrams)				
	EC (Enteric Coated) tablet. Take 325 Mg by mouth daily." The physician's order was marked as resume.				
	The physician's hospital discharge orders, dated 4/21/12, indicated "aspirin EC tablet 325 mg, 325 mg, oral daily, first dose on FRI (Friday) 3/30/12 at 0900 (9:00 a.m.). DO not crush. Continue No (indicated by a check mark)."				
	The resident's admission physician's orders, dated 4/21/12, indicated orders for				

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	OF CORRECTION IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/15/2012
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ILL ST RAISO, IN 46383	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	both the enteric coated aspirin 325 milligrams and aspirin 325 milligrams to be administered daily.			
	A physician's order, dated 4/23/12, indicated "d/c (discontinue) aspirin 325 mg"			
	The April MAR, dated April 21, 2012, indicated enteric coated aspirin 325 milligrams every day. (Next to the medication was handwritten see other page.)			
	The MAR, dated 4/21/12, indicated the resident received the regular (not enteric coated) aspirin from 4/22/12 thru 4/30/12. The resident continued to receive the non-enteric coated aspirin six days after the aspirin had been discontinued.			
	The May 2012, physician's recapitulation orders lacked documentation of an order for the enteric coated aspirin.			
	The May 2012, MAR lacked documentation of the enteric coated aspirin being given.			
	A physician's order, dated 5/8/12, indicated "Enteric coated aspirin 325 mg po (orally) QD (every day).			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155166	B. WING		05/15/2012
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
VALPAR	AISO CARE AND I	REHABILITATION CENTER	606 WA	RAISO, IN 46383	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5) COMPLETION
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
TAG		n 5/9/12 at 10:00 a.m., The	TAG	DEFICIENCY)	DATE
		ger indicated only one of			
	· · · · · · · · · · · · · · · · · · ·	rs should have been			
	_	She indicated the resident			
		received regular aspirin.			
		ne aspirin should have			
		ated. She indicated there			
		urses working on the			
		sion orders. She indicated			
		liscontinued the wrong			
		pharmacy had dropped the			
	aspirin on the pl	hysician's orders			
	recapitulation. S	She indicated the resident			
	should have got	ten the enteric coated			
	aspirin for the n	nonth of May.			
	3.1-35(g)(2)				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166		LDING	00	(X3) DATE : COMPL 05/15/	ETED
	PROVIDER OR SUPPLIER	EHABILITATION CENTER		606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0309 SS=D	must provide the services to attain practicable physic psychosocial well the comprehensive care. Based on record facility failed to and services wer with insulin coversugars (sliding serviewed for insusample of 24. (R #138) Findings include 1. Resident #138 on 05/07/12 at 13 diagnoses include to, impaired renamellitus. The resident's Phorders, dated 05 originally writter Check (blood sugtimes daily, Lant bedtime, and No scale order (insu	st receive and the facility necessary care and or maintain the highest cal, mental, and being, in accordance with re assessment and plan of review and interview, the ensure appropriate care exprovided to residents erage for high blood cale) for 3 of 6 residents allin coverage in a total esidents #51, #57, and	F03	09	F309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary of and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. What corrective action(s) will to have been affected by the deficient practice Resident's #51, #57 and #138 are receiving insulin as prescribed. The residents' physician were notified of the medication error. No new orders were received for any residents note. How will you identify other residents having the potential be affected by the same defici practice and what corrective action will be taken All residents have the potential to be affected by the alleged deficient practice. Nurses will be educated following physician's orders	e I d ns ed. to ent	06/07/2012

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/15/2012
		13.00	B. WING	ADDRESS CITY STATE ZIR CORE	1 00. 10.20 12
NAME OF P	ROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP CODE	
VALPAR	AISO CARE AND F	REHABILITATION CENTER		RAISO, IN 46383	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	_	nits, 201-250-nine		regarding insulin by the SDC/designee by 5/29/12.	
	unitsdo not use	e scale at HS (bedtime)."		DNS/designee have	
				audited all resident physiciar	n
	The, "Blood Glu	cose Monitoring Tool",		orders to ensure that all	
	dated 04/12, ind	icated the following Accu		physicians' orders are being	
	Check results an	d insulin administration:		followed.	
				What measures will be put in	uto
	04/06/12 at 9 p.r	n., blood sugar was 243		place or what systemic chan	
	•	f insulin given (should not		you will make to ensure that	~
		iding scale insulin).		deficient practice does not re	ecur
	110, 0 10001, 00, 51	iumg soure mounts).			
	04/07/12 at 9 n r	n., blood sugar was 159		 Unit Manager/designed audit the Blood Glucose 	e will
	and eight units of	_		Monitoring tool daily in clinical	اد
	and eight units of	n msumi given.		meeting (Mon-Fri) to ensure	
	04/10/12 + 0	11 1 210		physicians' orders for insulin	
		m., blood sugar was 218		administration have been	
	and nine units of	finsulin given.		followed.	
				DNS/designee will assign	gn a
		n., blood sugar was 202		license nurse to review the medication be accomplished	,
	and nine units of	f insulin given.		for those residents foun	
				· administration records	
		n., blood sugar was 124		to ensure medications have	been
	and no insulin w	as given.		administered per physician	
				orders.	
	04/19/12 at 6 a.r	n., blood sugar was 134		How the corrective action(s)	will
	and no insulin w	as given.		be monitored to ensure the	
				deficient practice will not rec	ur,
	04/19/12 at 9 p.r	n., blood sugar was 219		i.e., what quality assurance	
	and nine units of			program will be put into place	e
		Ç		The Unit Managers wi	ıı İ
	04/20/12 at 6 a r	n., blood sugar was 127		complete the "MAR/TAR" CO	
	and no insulin w	_		tool will be utilized weekly x	4,
	and no mount w			then monthly ongoing therea	
	04/22/12 at 6 a #	n., blood sugar was 106		Data will be submitted	
				the CQI Committee for review	N
	and no insulin w	as given.		and follow up.	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MU A. BUIL B. WING	LDING	onstruction 00	(X3) DATE COMPL 05/15	LETED	
	PROVIDER OR SUPPLIER	EHABILITATION CENTER	•	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE RIATE	(X5) COMPLETION DATE
	-	n., blood sugar was 229 Tinsulin was given.			Noncompliance with procedures may result in disciplinary action.	facility	
04/24/12 at 9 p.m., blood sugar was 244 and nine units of insulin was given. 04/27/12 at 6 a.m., blood sugar was 125 and no insulin was given.							
	04/28/12 at 9 p.m., blood sugar was 194 and eight units of insulin was given.						
	_	n., blood sugar was 232 Yinsulin was given.					
	04/30/12 at 11 a. and no insulin w	m., blood sugar was 113 as given.					
	dated 05/12, indi	cose Monitoring Tool," cated the following Accu d insulin administration:					
		n., blood sugar was 273 nsulin was given.					
	•	n., blood sugar was 183 f insulin was given.					
	p.m., the West U	iew on 05/07/12 at 1:50 init Manager indicated not receive her insulin as					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		00	COMPL	ETED
		155166	B. WING			05/15/	2012
			_	EET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ER			ALL ST		
VALPAR	AISO CARE AND	REHABILITATION CENTER			RAISO, IN 46383		
(X4) ID		STATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX			PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAC	j	DEFICIENCY)		DATE
		1's record was reviewed on					
		25 a.m. The resident's					
		ded, but were not limited					
	to, diabetes me	llitus and kidney failure.					
	The Physician's	Recapitulation Orders,					
	1	dicated, "Novologper					
	· ·	times daily151-200=2					
	units, 201-250=	-					
	,						
	The, "Capillary Blood Glucose						
	Monitoring Too	ol," dated 04/12, indicated					
	the resident's 4	p.m. blood sugar on					
		12 and no insulin had been					
	administered.						
	warrang vor our						
	The, "Capillary	Blood Glucose					
	Monitoring Too	ol," dated 05/12, indicated					
	the resident's 4	p.m. blood sugar on					
	05/08/12 was 1	69 and no insulin was					
	administered to	the resident.					
	_	view on 05/10/12 at 11:05					
		or of Nursing indicated the					
	resident had no	t received the insulin as					
	ordered by the	physician.					
	3 Resident #57	's record was reviewed on					
		0 a.m. Resident #57's					
		ded, but were not limited					
	_	llitus, congestive heart					
		_					
	failure, and asth	IIIIa.					
	Physician recap	oitulation orders, dated					

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Event ID: 005011

Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155166	B. WIN	G		05/15/	2012
NAME OF P	PROVIDER OR SUPPLIER		_	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI LIER			606 WA			
VALPAR	AISO CARE AND R	REHABILITATION CENTER		VALPAF	RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	* *	ated an order (originally					
	· · · · · · · · · · · · · · · · · · ·	for blood sugar checks					
	1	with Humalog (insulin)					
	sliding scale.						
	Physician recani	tulation orders, dated					
May 2012, indicated an order (originally							
		for Humalog 100					
	·	nject subcutaneous per					
	· · · · · · · · · · · · · · · · · · ·	ee times daily with meals:					
shang scale tince times daily with inears.		times during with medis.					
100-150= 4 units		S					
	151-200= 6 units	S					
	201-250= 8 units	S					
	251-300= 10 uni	its					
	301-350= 12 uni	its					
	351-400= 14 uni	its					
	Call MD if less t	than 70 or greater than					
	400						
		Glucose Monitoring					
		blood glucose levels and					
		in was given, on the					
	following dates a	and times:					
	4/12/12 at 4 n m	. 115 and no insulin was					
	given						
	~	. 118 and no insulin was					
	given	. 110 min ito moniii wuo					
	~	. 117 and no insulin was					
	given						
	5/7/12 at 4 p.m.	153 and 4 units of insulin					
	given						
	5/8/12 at 6 a.m.	159 and 4 units of insulin					

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PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155166	(X2) MULTIPLE CON A. BUILDING B. WING	00	COMP	ESURVEY LETED 5/2012		
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE		
	During an interview with the East Unit Manager, on 5/10/12 at 1 p.m., she indicated the insulin was not given as ordered on 4/12, 4/13, 4/17, 5/7, and 5/8. 3.1-37(a)						

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Event ID: 005011

Facility ID: 000083

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	COMPLETED			ETED	
		155166	A. BUILD			05/15/	2012
			B. WING	_		000.	
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
				606 WA			
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPAF	RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0314 SS=D	483.25(c) TREATMENT/SV PRESSURE SOF Based on the con a resident, the fact resident who enter pressure sores do sores unless the condition demons unavoidable; and sores receives ne services to promo infection and previous developing. Based on observ interview, the fact resident's physic re-opened and fact a resident with a failed to administ as ordered to pro- affected 2 of 8 re ulcers in a sampl (Residents B and Findings Include 1. Resident B's re 5/7/12 at 1:15 p. diagnoses includ to, diabetes mell sclerosis.	CS TO PREVENT/HEAL RES Inprehensive assessment of cility must ensure that a gers the facility without the pes not develop pressure individual's clinical strates that they were a resident having pressure recessary treatment and the healing, prevent went new sores from the action, record review, and cility failed to notify the fian when a area filed to thoroughly assess pressure ulcer (B), and there a protein supplement formote healing (C). This residents with pressure the of 24 residents. In C) The second was reviewed on the many reviewed on the ma	F031			ot s ces ction sing	DATE 06/07/2012
	assessment, date Resident B was a	(minimum data set) d 3/27/12, indicated alert and oriented. The t indicated the resident			Resident B's physician y notified on April 27, 2012 durir wound clinic visit. Her primary physician and her physician at	ng a ′	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLE	ETED
		155166	B. WING			05/15/2	2012
N	DOLUBER OF	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	K		606 WA			
	AISO CARE AND I	REHABILITATION CENTER		VALPA	RAISO, IN 46383		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG		Ļ	DATE
	_	with two staff assist for			wound clinic are the same. Tre-opened area was assed.	ne	
	1	d transfers. The MDS			Resident C's physiciar	ı was	
		cated the resident was			notified and no new orders w		
	nonambulatory,	had impairment for			received. The Promod was		
	movement on b	oth sides of the body, and			discontinued upon her admis		
	was always inco	ontinent of bowel. The			to the hospital on 4/16/12 and	d not	
	1	tage II pressure ulcers			reordered.		
	present upon ad				How will you identify other		
	ritter apon ad				residents having the potent	ial	
	A care plan dat	ed 1/3/12, indicated the			to be affected by the same	···	
	_	open area to the great			deficient practice and what		
		open area to the great			corrective action will be tak	en	
	right toe.						
					· Residents residing in t		
		nd skin evaluation report,			facility have the potential to b		
	dated 3/14/12, i	ndicated the right great toe			affected by the alleged defici-	ent	
	was a stage II p	ressure ulcer. The notes			Licensed nurses will be	_	
	indicated "me	t to discuss skin			re-educated on following		
	status-Resident	conts (continues) with			physician orders and		
		ht) gt (great) toeSevere			receive/note/discontinuing		
		nt to BLE (bilateral lower			physicians' orders by the		
		oot cause of wounds conts			DNS/designee by 5/29/12.		
	· · · · · · · · · · · · · · · · · · ·				 All residents were assessed to ensure any oper 	,]	
		e pressure secondary to			areas were being addressed		
	contractures"				physicians were notified of ar		
	<u></u>				concerns.		
	1 -	rder, dated 3/20/12,			· DNS/designee have		
	indicated "Clear	nse r (right) gr (great) toe			audited all resident physician		
	c/ (with) 0.9% r	ns (normal saline) apply			orders to ensure that all		
	medihoney (typ	e of wound treatment)			physicians' orders are being followed.		
	fluffed gauze at	od (abdomen) pad et (and)			ioliowed.		
	gauze roll."				What measures will be put i	nto	
					place or what systemic		
	Δ nurses' note	dated 4/17/12 at 2:59 p.m.,			changes you will make to		
		_			ensure that the deficient		
		en area to the resident's			practice does not recur		
	right great toe h	ad resolved. The nurses'					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155166	B. WING	J		05/15/	/2012
				REET A	ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIEF	₹			LL ST		
VALPAR	AISO CARE AND F	REHABILITATION CENTER			RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL				TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TA	G	DEFICIENCY)		DATE
		ne resident's physician had			· The Director of Nursing		
		d a new order had been			Services is responsible to mor		
	received to disco	ontinue the treatment to			for facility compliance.	11101	
	the resident's toe.				· The Interdisciplinary Te	am	
					reviews the physician orders a		
	Further review of nurses' note indicated				the clinical meeting (Mon-Fri).		
	the treatment to	the resident's right great			 Skin assessments are conducted twice weekly during 	~	
	toe was administered on 4/18/12, 4/19/12, and 4/21/12.				shower/bed bath by a charge	J	
					nurse to identify any skin		
	-1/19/12, and -1/2	1/12.			concerns.		
	A mumacal mata	lated 4/21/12 at 4:16 m m			· DNS/designee will assign	gn a	
	•	lated 4/21/12 at 4:16 p.m.,			license nurse to review the		
	indicated the right great toe was open and				medication administration reco		
	pink.				daily to ensure medications ha		
					been administered per physic orders.	ian	
	There was a lack	of documentation in the			· The Unit		
	resident's record	to indicate the resident's			Managers/designee will audit	the	
	physician was no	otified of the resident's			MAR/TAR's to ensure physicia		
	great right toe re				orders are followed (Mon-Fri).		
		opening.			The MAR/TAR CQI tool will be		
	An interview on	5/8/12 at 10:05 a.m., the			utilized weekly x 4, then month	hly	
		· · · · · · · · · · · · · · · · · · ·			ongoing thereafter.		
		idicated she could not find					
		ontinue the treatment			How the corrective action(s)		
		ian was notified of the			will be monitored to ensure to		
	1	healed. She indicated the			deficient practice will not red		
	nurse had not no	tified Resident B's			i.e., what quality assurance		
	physician when	the area to the great right			program will be put into place	e	
	toe had reopened	d on 4/21/12.			· The Unit Managers will		
					complete the "MAR/TAR" and		
	A pressure wour	nd skin evaluation, dated			"Skin Management Program"		
	•	ed the area to the great			tool will be utilized weekly x 4, then monthly ongoing thereaft		
	· ·	tage 2 and measured 0.4			Data will be submitted t		
	_	•			the CQI Committee for review		
	1	4 centimeter with a depth			and follow up.		
	less than 0.1 cen	itimeter.			Noncompliance with fac	cility	
					procedures may result in		

	OF CORRECTION OF CORRECTION 155166 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/15/2012			
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION			
	There was no further documentation of a pressure wound skin evaluation report until 5/8/12.		disciplinary action.				
	The pressure wound skin evaluation report, completed by the Wound Nurse, dated 5/8/12, indicated the area to the great right toe was a stage 2 and measured 0.4 centimeter by 0.4 centimeter and was at a depth of 0.2 centimeter. The depth of the pressure ulcer had increased						
	On 5/9/12 at 2:30 p.m., the Wound Nurse was observed to measure the resident's right great toe. The measurements the Wound Nurse recorded were 0.4 centimeter by 1 centimeter with a depth of less than 0.1 centimeter.						
	2. Resident C's record was reviewed on 5/09/12 at 9:00 a.m. Resident C's diagnoses included, but were not limited to, diabetes mellitus, hypertension, seizure disorder, malnutrition, respiratory failure, circulatory shock, shortness of breath, and congestive heart failure.						
	A physician's order, dated 3/28/12 at 12:30 p.m., indicated an order for "Promod (protein supplement) 60 cc (cubic centimeters) per peg tube (feeding tube) q (every) 8 hours x (for) 30 days." The order indicated promod was ordered to aid with wound healing due to low						

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Event ID: 005011

Facility ID: 000083

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	OF CORRECTION OF CORRECTION 155166	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/15/2012
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	606 WA	ADDRESS, CITY, STATE, ZIP CODE ALL ST RAISO, IN 46383	3
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	albumin level. The MAR (Medication Administration Record), dated 4/12, lacked documentation for the order for Promod 60 cc per Peg Tube every 8 hours for the remaining 28 days. The Nurses' Notes indicated: 4/01/12 at 2:37 a.m., "Cont (continue) Promod per order." 4/01/12 at 1:34 p.m., "Promod received for wound healing." 4/01/12 at 7:53 p.m., "Receives promod for wound healing." A nurses' note, dated 5/8/12 at 6:32 a.m., indicated "Areas to right buttocks resolved." During an interview, with the West Unit Manager on 5/09/12 at 11:40 a.m., the West Unit Manager indicated the Promod did not get transcribed or written on the 4/12 physician's recapitulation or the MAR. This Federal tag relates to complaint IN00108232. 3.1-40(a)(1) 3.1-40(a)(2)			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CC A. BUILDING B. WING	00		TE SURVEY MPLETED 15/2012	
		REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BLUE DING 00			(X3) DATE SURVEY COMPLETED		
		155166	A. BUILDING B. WING			05/15/2012	
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			606 WA			
VALPAR	AISO CARE AND R	EHABILITATION CENTER			RAISO, IN 46383		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0315	483.25(d)						
SS=D	BLADDER	PREVENT UTI, RESTORE					
		ident's comprehensive					
		facility must ensure that a					
		ers the facility without an					
	_	er is not catheterized unless					
	the resident's clinical condition demonstrates						
that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to							
	restore as much normal bladder function as possible.						
	Based on record	review and interview, the	F03	15	F315 NO CATHETER,		06/07/2012
	facility failed to ensure a resident was				PREVENT UTI, RESTORE		
	accurately assess	sed for bladder			BLADDER		
	incontinence and	l provided treatment to			Based on the resident's		
	restore as much	normal bladder			comprehensive		
	functioning as po	ossible for 1 of 17			assessment, the facility must		
		ents in a sample of 24.			ensure that a		
	(Resident #30)	•			resident who enters the facility	/	
	(======================================				without an indwelling catheter is not catheterize	ad	
	Findings include	·			unless the resident's clinical condition		
	i mamga marada	•			demonstrates that catheterization was	as	
	Resident #30's ra	ecord was reviewed on			necessary; and a resident who is incontinent of bladder receives		
		m. Resident #30's			appropriate		
					treatment and services to prev	vent	
	~	ed, but were not limited			urinary tract infections and to restore as much normal bladd	or	
	· ·	tia, depression, and			function as possible.	lei	
	hypertension.				What corrective action(s) wil	ıı İ	
					be accomplished for those		
		DS (Minimum Data Set)			residents found to have been	n	
	assessment, date	d 3/26/12, indicated			affected by the deficient		
	Resident #30 wa	s alert and oriented,			practice		
	required extensiv	ve assist of two staff for			A bladd		
	bed mobility and	I transfers. The MDS			 A bladder assessment v completed for resident #30 an 		
	1	ated the resident was			the resident need sheet and c		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLETED
		155166	B. WIN			05/15/2012
			B. WII		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER					
\/AI DAD	AISO CADE AND D	EHADII ITATION CENTED	606 WALL ST VALPARAISO, IN 46383			
VALPAR	VALPARAISO CARE AND REHABILITATION CENTER			VALPA	RAISO, IN 40363	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	nonambulatory and was dependent with				plan has been updated.	
	two staff assist for	or toilet use.				
					How will you identify other	
	A CAA (Coro A	ran Assassmant			residents having the potentia	al
	A CAA (Care A				to be affected by the same	
	• / ·	d 3/28/12, indicated the			deficient practice and what	
	resident would b	e care planned for the			corrective action will be take	n
	problem area of	urinary incontinence.			Dooidonto who reside -	.
					 Residents who reside a the facility have the potential t 	
	Review of Resid	ent #30's care plans,			affected by the alleged deficie	
					practice.	
dated 4/18/12, indicated a lack of					Licensed nurses will be	
documentation of a care plan for the				re-educated on Bladder		
	problem area of	urinary incontinence.			Assessments by the	
					DNS/designee by 5/29/12.	
	An interview on	5/9/12 at 11:00 a.m., the			 MDS Coordinator/desig 	nee
	East Unit Manag	ger indicated there was			audited all current resident	
	1	the resident's record for			Bladder Assessments for	
	urinary incontine				accuracy and all residents with	
		ence.			discrepancies identified receiv a new bladder assessment. T	
					care plan was updated as well	-
		adder assessment, dated			the resident needs sheet to re	
	3/23/12, indicate	ed the resident was			the changes.	noot
	"always continer	nt."			Bladder assessments are	
					completed by the DNS/design	ee
	An ADI (Activi	ties of Daily Living)			upon admission, re-admission	
	,	arch 2012, indicated the			significant change, quarterly,	
	· ·				annually and when an indwelli	~
		ontinent on the following			urinary catheter is removed.	
	dates:				MDS Coordinator/designee wi	
	3/19/12, six time	es			audit all of the bladder	
	3/20/12, eight tir	nes			assessments to ensure	1014
	3/21/12, six time				completion and accuracy. A n bladder assessment will be	ICAA
	3/22/12, six time				completed	
	· · · · · · · · · · · · · · · · · · ·				· when discrepancies are	,
	3/23/12, five tim				noted. The resident needs sh	
	3/24/12, nine tim				will be updated based on the r	
	3/25/12, six time	es			assessment.	
					· The DNS/designee will	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	ILDING	00	COMPLETED
		155166	B. WIN			05/15/2012
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER			606 WA		
VALPAR	AISO CARE AND R	EHABILITATION CENTER			RAISO, IN 46383	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (X	
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG		DATE
	Further review o	f the ADL sheets for			monitor for compliance.	
	March, April, an	d May, 2012, indicated			Noncompliance with fact	ility
	the resident was	_			procedures may result in	
	the resident was	meontment.			disciplinary action.	
	The resident care	e/need sheet, dated			What measures will be put in	to
		ted the resident was			place or what systemic	
	•	icu ine resident was			changes you will make to	
	continent.				ensure that the deficient	
					practice does not recur	
	There was a lack	of documentation in the			-	
resident's record to indicate the resident				· Data to develop a plan o	of	
		g program or how often			care for Incontinence/Continer	nce
	she was being ta				will be obtained from the ADL	
	she was being ta	ken to the tonet.			documentation. When the	
					bladder assessment is comple	
	During an interv	iew on 5/9/12 at 11:00			MDS will complete the Care P	
	a.m., the East Ur	nit Manager indicated the			and the resident needs sheet	will
	resident was free	quently incontinent from			be updated.	
	· ·	3/12. She indicated the			The care plan will be	an
		ent was incorrect. She			completed as indicated based the issues identified with the	Off
					completion of the comprehens	ive
		ident was not on a			MDS/CAA process.	
		n and the care/needs sheet			· The care plan meeting	
	was incorrect.				guideline form will be utilized b	ру
					the MDS Coordinator /designe	
	3.1-41(a)(2)				to ensure triggered CAAS	
	(#)(=)				requiring a care plan will have	а
					care plan in place.	
					Bladder assessments are	
					completed by the DNS/design	
					upon admission, re-admission	,
					significant change, quarterly, annually and when an indwelli	na
					urinary catheter is removed.	
					MDS Coordinator/designee wi	
					audit all of	"
					the bladder assessment	s to
					ensure completion and accura	
					A new bladder assessment wi	-
					completed when discrepancies	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPLE CO A. BUILDING	00	COMPLETED	
		B. WING		05/15/2012	
	ROVIDER OR SUPPLIE AISO CARE AND F	REHABILITATION CENTER	606 W	ADDRESS, CITY, STATE, ZIP CO ALL ST RAISO, IN 46383	DDE
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
			are noted. The resident sheet will be updated by the new assessment. The DNS is responsive resident's plan or resident need sheet is a accurate reflection of resident.	ased on onsible to of care and an	
				How the corrective act will be monitored to er deficient practice will r i.e., what quality assur program will be put int	nsure the not recur, rance
				The Restorative I complete the "Bladder I and "Assessment" CQI utilized weekly x 4, then thereafter. Data will be subn the CQI Committee for and follow up. Noncompliance v procedures may result i disciplinary action.	Program" tool will be n monthly nitted to review with facility

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 005011

Facility ID: 000083

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLE	ETED
		155166		B. WING 05/15/2012			2012
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIER			606 WA			
VALPAR	AISO CARE AND R	EHABILITATION CENTER		VALPAI	RAISO, IN 46383		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0328 SS=D	The facility must of receive proper tree following special subjections; Parenteral and er Colostomy, ureter Tracheostomy car Tracheal suctioning Respiratory care; Foot care; and Prostheses. Based on record facility failed to	nteral fluids; rostomy, or ileostomy care; re; ng;	F03	28	F328 TREATMENT/CARE FOI SPECIAL NEEDS The facility must ensure that	र	06/07/2012
	,	d for 2 of 7 residents a sample of 24. and #130)			residents receive proper treatment and care for the following special services: Injections, parenteral and ente fluids; Colostomy, ureterostom or ileostomy care; Tracheal suctioning; Respirator care; Foot care; and Prostheses.	y, y	
	on 05/10/12 at 83 diagnoses includ	O's record was reviewed 15 a.m. The resident's ed, but were not limited ilure and convulsions.			What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice		
	dated 05/12 and 01/09/12, indicate oximetry (O2 sate The "Ventilator/indicated the residuent completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the completed of the complete of the compl	Recapitulation Orders, originally ordered on ted to check the pulse turations) twice daily. Aerosol Flow Sheets," ident's O2 saturations had once a day not two times on 04/06/12, 04/16/12,			Resident #110 and resident #138 have their oxygen stats checked as physicians ordered. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken	d. I	
		· · · · · · · · · · · · · · · · · ·			· Residents who use oxyg	gen	

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Event ID: 005011

Facility ID: 000083

If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			ETED	
		155166	A. BUII B. WIN			05/15/2	2012
			D. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹		606 WA			
VΔΙ ΡΔ Ρ	AISO CARE AND E	REHABILITATION CENTER			RAISO, IN 46383		
					10 11000, 111 10000		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	have the potential to be affected	- d	DATE
	04/20/12, 04/26/12, 04/29/12, and 05/06/12.				by the alleged deficient practice.		
					Licensed nurses and		
					respiratory staff will be		
	During an interv	riew on 05/10/12 at 8:45			re-educated on following		
	a.m., the Respira	atory Therapy Manager			physician orders by the		
	indicated the ox	ygen saturations had not			SDC/designee by 5/29/12.		
		as ordered on the above			DNS/designee have audited all resident physician		
	dates.				orders in regards to oxygen st	ats	
					to ensure that all physicians'		
	2 Resident #13	0's record was reviewed			orders are being followed.		
	on 05/08/12 at 1:15 p.m. The resident's diagnoses included, but were not limited						
					What measures will be put in	ito	
		and chronic respiratory			place or what systemic		
	failure.				changes you will make to ensure that the deficient		
					practice does not recur		
	1	Recapitulation Orders,			F		
	dated 05/02 and	originally dated			Respiratory		
	03/19/12, indica	ted an order for pulse			Supervisor/designee is		
	oximetry twice of	daily.			responsible to ensure complia	nce	
					with facility procedure for		
	The "Ventilator/	'Aerosol Flow Sheets",			compliance with physician ord	ers	
		ident's O2 saturations had			· Respiratory	-: •.	
	been completed	once a day not twice a			Supervisor/designee will assig		
		on March 22, 23, and 31,			Respiratory Therapist to review	N	
	_	0, 14, 17, 19, 23, and 29,			the "Ventilator/Aerosol Flow	.	
	2012, April 3, 10 2012.	0, 14, 17, 19, 23, and 29,			Sheets" daily to ensure physic		
	2012.				orders are followed for accura The Respiratory	cy.	
	Danie a ve int	.i 05/00/12 -4 10:15			Supervisor/designee will audit	the	
		riew on 05/09/12 at 10:15			"Ventilator/Aerosol Flow Shee	ts"	
		atory Therapy Manager			daily Monday through Friday for	or	
	indicated the O2 saturations were not				accuracy.		
	completed as ord	dered on the above dates.			How the corrective action (a)		
					How the corrective action(s) will be monitored to ensure t	ho	
	3.1-47(a)(6)				deficient practice will not rec		
					i.e., what quality assurance	·u1,	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155166	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/15/2012		
VALPARA	PROVIDER OR SUPPLIE	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE COMPLETION DATE		
				Program will be put into Respiratory Supervisor/designee will complete the "Oxygen To CQI tool 3 times weekly once weekly x 4 weeks a monthly ongoing thereaf Data will be submethe CQI Committee for reand follow up. Noncompliance weekly procedures may result in disciplinary action.	herapy" x 4, the and then iter. itted to eview		

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Event ID: 005011

Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		(X2) MULTIPI A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2012		
	PROVIDER OR SUPPLIED	REHABILITATION CENTER	STR 606	EET ADDRESS, CITY, STATE, ZIP CODE 3 WALL ST LPARAISO, IN 46383	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS-REFERENCED TO THE APPRO	OBE COMPLETION
F0333 SS=D	ERRORS The facility must free of any signif Based on record facility failed to from a significate related to high befor 1 of 24 resides significant medissample of 24. (Findings included Resident #138's 05/07/12 at 1:20 diagnoses included to, impaired remmellitus. The hospital dis 03/16/12, indicate Lopressor (antile (milligrams), two blood pressure (hold on dialysis Wednesday, and The facility admonstrated of 12, indicate (antihypertensive twice daily. Hol	record was reviewed on p.m. The resident's ded, but were not limited al failure and diabetes charge orders, dated ated an order for hypertensive) 12.5 mg ice daily. Hold if systolic SBP) less than 105 and days (Monday,	F0333	F333 RESIDENTS FREE SIGNIFICANT MED ERROTHe facility must ensure the residents are free of any significant medication error what corrective action(s) be accomplished for those residents found to have affected by the deficient practice Resident #138 physical was notified of the medical error. No new orders were received for this resident. How will you identify othe residents having the potential to be affected by the same deficient practice and whe corrective action will be antihypertensive medication the potential to be affected alleged deficient practice. DNS/designee have audited all resident physicion orders to ensure that all physicians' orders are being followed for antihypertensimedication. Licensed nurses will re-educated on following physician orders by the DNS/designee by 5/29/12	ORS at rs. will se peen cician tion e er ential ne cat caken on have d by the cian ng ve I be

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COM			COMPLET	ED
		155166	B. WING	i.		05/15/20)12
		ı		REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	3		06 WAI			
VALPAR	AISO CARE AND F	REHABILITATION CENTER			RAISO, IN 46383		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX			PRE	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	The MAR (Medication Administration Record), dated 4/12 and 5/12, lacked documentation to hold the Lopressor as ordered above. The 2010 Nursing Spectrum Drug Book, pages 750-751, indicated Lopressor precautions were to use cautiously in renal impairment. The MAR, dated 04/12, indicated the				What measures will be put in place or what systemic changes you will make to ensure that the deficient practice does not recur	to	
					The Director of Nursing Servis responsible to monitor for facility compliance. The Interdisciplinary Terreviews the physician orders at the clinical meeting (Mon-Fri). DNS/designee will assignee assignee assignee to review the	am t	
	resident received the Lopressor on				license nurse to review the medication administration reco	orde	
		•			daily to ensure antihypertensiv	I .	
		02/12 at 9 a.m. and 9			medications have been		
		t 9 p.m., 04/16/12 at 9			administered per physician		
		04/23/12 at 9 p.m., and			orders.		
	04/30/12 at 9 a.r	n. and 9 p.m.			· The Unit		
					Managers/designee will audit to MAR/TAR's to ensure physicial		
	The MAR, dated	d 04/12, indicated the			orders are followed (Mon-Fri).	1115	
	resident received	d the Lopressor on			The MAR/TAR CQI tool will be	,	
	Wednesdays on	04/04/12 at 9 p.m.,			utilized weekly x 4, then month	nly	
		m., 04/18/12 at 9 p.m.,			ongoing thereafter.		
	•	9 a.m. and 9 p.m.			Hamaka a garage		
		1			How the corrective action(s)	,	
	The MAR dated	d 04/12, indicated the			will be monitored to ensure t deficient practice will not rec		
		d the Lopressor on Fridays			i.e., what quality assurance	·ui,	
		p.m., 04/13/12 at 9 a.m.		1	program will be put into plac	e	
		•			. 5		
	_	0/12 at 9 p.m., and			· The Unit Managers will		
	04/27/12 at 9 p.1	n.			complete the "MAR/TAR" CQI		
					tool will be utilized weekly x 4,		
	The MAR, dated	d 05/12, indicated the		1	then monthly ongoing thereafted to	I	
	resident received	d the Lopressor on			 Data will be submitted to the CQI Committee for review)	
	Wednesday 05/0	02/12 at 9 p.m. and Friday			and follow up.		
	05/04/12 at 9 p.1	-		1	Noncompliance with fac	ility	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155166	A. BUILDING B. WING	00	COMP	COMPLETED 05/15/2012	
	PROVIDER OR SUPPLIER AISO CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	During an interview on 05/07/12 at 1:05, the Staff Development Nurse indicated the resident's Lopressor had not been held on dialysis days as ordered by the physician. 3.1-25(b)(9) 3.1-48(c)(2)		procedures may result in disciplinary action.			

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Event ID: 005011

Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING 00		COMPLETED	
		155166	B. WING			05/15/	2012
	PROVIDER OR SUPPLIE	REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST VALPARAISO, IN 46383				
				VAIGO, IIV 40000			
(X4) ID		TATEMENT OF DEFICIENCIES	D	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	``				CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	
F0508 SS=D	REGULATORY OF 483.75(k)(1) PROVIDE/OBTA RADIOLOGY/DIA The facility must and other diagnored of its resion responsible for the services. Based on record facility failed to ordered by a reservices are sidents reversed testing in a total facility failed to ordered by a reservice of the services. Findings included Resident #138's 05/07/12 at 1:20 diagnoses included to, impaired remember of the mellitus. A physician order indicated an order ordered an order ordered as ordered as ordered as ordered as ordered as ordered as ordered the KUB had not the services and black the KUB had not the services are serviced to the services and black the services are serviced to the services	AGNOSTIC SVCS provide or obtain radiology stic services to meet the lents. The facility is ne quality and timeliness of review and interview, the obtain an x-ray as ident's physician for 1 of iewed for radiology sample of 24. (Resident e: record was reviewed on p.m. The resident's led, but were not limited al failure and diabetes er, dated 04/13/12, er for a KUB (kidney, lder) x-ray. ecord lacked he KUB had been dered by the physician. riew on 05/07/12 at 1:50 Unit Manager indicated t been completed. LPN		REFIX TAG	F508 PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS The facility must provide or ob radiology and other diagnostic services to meet the needs of residents. The facility is responsible for the quality and timeliness of the services. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice Resident #138 physician was notified and the order for KUB had been discontinued provided but the nurse failed to write the order to discontinue. The physician determined that the KUB was not necessary. How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be take Residents residing in the facility have the potential to be	tain its In the rior e	O6/07/2012
	#5 indicated the	x-ray company came to			affected by the alleged deficient practice.	nt	

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Facility ID: 000083

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
AND TEAN	or conduction	155166	A. BUILDING		05/15/2012
			B. WING STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R	606 W		
VALPAR	AISO CARE AND F	REHABILITATION CENTER	VALPA	RAISO, IN 46383	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
	1	completed the resident's		DNS/designee have audited all resident physician	
	1	could not get the KUB		orders to ensure that all	
		indicated it was shift		physicians' orders are being	
		as unsure what happened		followed.	
		ndicated the KUB had not		 Licensed nurses will be re-educated on following 	
	been reschedule	a.		physician orders and	
	2.1.40()			receive/note/discontinuing	
	3.1-49(g)			physicians' orders by the	
				DNS/designee by 5/29/12. What measures will be put in	ıto .
				place or what systemic	
				changes you will make to	
				ensure that the deficient	
				practice does not recur	
				The Director of Nursing	
				Services is responsible to mor	
				for facility compliance.	
				The Interdisciplinary Te	am
				reviews the physician orders/labs/diagnostics at the	
				clinical meeting (Mon-Fri).	
				· DNS/designee will assign	gn a
				license nurse to review the	suro.
				lab/diagnostics log daily to ensight physician orders are followed.	
				How the corrective action(s)	
				will be monitored to ensure t	
				deficient practice will not rec i.e., what quality assurance	,ui,
				program will be put into place	е
				The SDC/designee will complete "Labs/Diagnostics"	
				tool will be completed weekly weeks then monthly ongoing.	x 4
				Data will be submitted t	o
				the CQI Committee for review	

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PRINTED: 11/05/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING	00	COMPLETED 05/15/2012				
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 606 WALL ST					
VALPARAISO CARE AND REHABILITATION CENTER			VALPARAISO, IN 46383					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	and follow up. Noncompliance with factorized procedures may result in disciplinary action.				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
155166		B. WING		05/15/2012				
				ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIE	R		ALL ST				
VALPARAISO CARE AND REHABILITATION CENTER				VALPARAISO, IN 46383				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
F0514	483.75(I)(1)							
F0514 SS=D	RES RECORDS-COM SSIBLE The facility must each resident in professional star are complete; ac readily accessib organized. The clinical reco information to id of the resident's care and service any preadmission the State; and p Based on record facility failed to complete and ac clarification of medications, an medications ad residents review accurate clinica of 24. (Resident Findings includ 1. A. Resident on 5/07/12 at 12 diagnoses inclu to,diabetes mell Obstructed Pulir	d review and interview, the ensure records were recurate related to a resident's allergy, d documentation of ministered for 2 of 24 red for complete and d records in a total sample as #72 and #138) e: #72's record was reviewed 2:00 p.m. The resident's ded, but were not limited itus, COPD (Chronic monary Disease), atrial ropathy, and right above	F0514	F514 Clinical Records The facility must maintain clin records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readi accessible; and systematically organized. The clinical record must conta sufficient information to identifithe resident; a record of the resident's assessments; the pof care and services provided results of any preadmission screening conducted by the State; and progress notes. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice	ly y ain fy lan ; the			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	f f		X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTI		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155166		B. WIN	05/15/2012				
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER				606 WA			
VALPARAISO CARE AND REHABILITATION CENTER				VALPARAISO, IN 46383			
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE	
	A physician's recapitulation orders, dated				Physician orders for		
	5/12, indicated a	n order for alprazolam			resident #72 were clarified her allergy order was discontinued		
	0.25 milligrams	tablet by mouth every 8			per physicians order.	'	
	hours as needed	for anxiety.			Resident #138 is receiv	ina	
					her insulin as prescribed.	9	
	A physician's or	der, dated 5/03/12 at			Documentation is accurate to		
					reflect that the resident is		
	12:00 p.m., indic				receiving insulin as prescribed	l.	
		evious prn (as needed)					
	ativanstart ativan 0.25 mg PO (by				How will you identify other		
	mouth) BID (tw	ice daily)."			residents having the potentia	al	
	The MAR, dated 05/12, indicated the resident had an order for prn alprazolam 0.25 mg. The MAR indicated the alprazolam 0.25 mg had been discontinued on 05/03/12. During an interview with the DoN (Director of Nursing) on 5/08/12 at 11:30 a.m., the DoN indicated she was not able				to be affected by the same		
					deficient practice and what corrective action will be take	_	
				corrective action will be taken		11	
					Residents residing in the facili	tv	
					have the potential to be affected	-	
					by the alleged deficient practic		
					Licensed nurses will be	ı	
					re-educated on following		
					physician orders and		
					receive/note/discontinuing		
					physicians' orders by the DNS/designee by 5/29/12.		
	to locate a prn or	rder for Ativan. She			DNS/designee by 5/29/12. DNS/designee have		
	indicated the resident was on prn				audited all resident physician		
					orders to ensure that all		
	alprazolam and that had been discontinued. B. Resident #72's resident information sheet (face sheet) indicated the resident's allergies as follows: ASA (aspirin), codeine sulfate, lyrica, oxycontin, adhesive tape, and latex.				physicians' orders are being		
					followed.		
					What measures will be put in	ito	
					place or what systemic		
					changes you will make to		
					ensure that the deficient		
					practice does not recur		
	• /				The Interdisciplinary Te	am	
	The Resident's P	Physician recapitulation			reviews the physician orders a		
		23/12 to 3/31/12, lacked			the clinical meeting (Mon-Fri).		
	•	-			· The Unit		
	aocumentation to	o indicate the resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SU		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	NUMBER: A. BUIL		00	COMPLETED		
155166		B. WIN			05/15/2012			
			D. WII		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER				606 WA				
VALPARAISO CARE AND REHABILITATION CENTER				VALPARAISO, IN 46383				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE		
	had any allergies. The physician's order				Managers/designee will audit t	• • • • • • • • • • • • • • • • • • •		
	recapitulations,	dated 4/12 and 5/12,			MAR/TAR's to ensure physician's			
	indicated the res	ident was allergic to			orders are followed (Mon-Fri).			
	hydrocodone.				 DNS/designee will assign license nurse to review the 	gn a		
	ny drocodone.				medication administration reco	orde		
	A 1 · · · 1	1 4 1 2 /22 /12			daily to ensure medications ha			
		er, dated 3/22/12,			been administered per physici			
	1	ocodone/acetamin			orders.			
	(acetaminophen)) (pain medication)						
	10-325 mg tab, 7	Γake 2 tablets (20-650			How the corrective action(s)			
	mg) by mouth e	very 4 hours as needed for			will be monitored to ensure t	he		
	pain." The Resident's MAR (Medication Administration Record), dated 3/12, indicated Resident #72 received hydrocodone on 3/23, 3/24, 3/26 twice, 3/28, and 3/31/12. The MAR, dated 4/12, indicated the resident received hydrocodone 4/1, 4/4,				deficient practice will not rec	ur,		
					i.e., what quality assurance			
					program will be put into plac	e		
					The Unit Managers will			
					complete the "MAR/TAR" CQI			
					tool will be utilized weekly x 4, then monthly ongoing thereaft			
					Data will be submitted to			
					the CQI Committee for review			
					and follow up.			
					Noncompliance with facility			
		•			procedures may result in			
		/10 twice, 4/13, 4/16			re-education and or disciplinar	у		
	three times, 4/17, 4/18 three times, 4/19, 4/20, 4/21, 4/22, 4/23, 4/24 twice, 4/28. 4/29 twice, and 4/30/12 twice.				action.			
	The MAR, dated 5/12, indicated the resident received the hydrocodone on 5/1							
		-						
	twice, 5/2 twice, 5/3 twice, 5/4 three times, 5/5 three times, 5/6, 5/7 three times, and 5/8/12.							
	A physicians ord	der, dated 5/09/12 at 2:15						
	p.m., indicated "	MD aware of allergy to						
	hydrocodone. It is OK to administer							

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
155166			LDING		05/15/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	NAME OF PROVIDER OR SUPPLIER				ILL ST	
VALPARAISO CARE AND REHABILITATION CENTER					RAISO, IN 46383	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
TAG	†	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE!	DATE
	·	-325 mg 2 tabs q (every) (as needed) for pain."				
	4ms (nours) prin	(as needed) for pain.				
	A physician's or	der, dated 5/09/12 at 4:00				
		"D/C (discontinue)				
	allergy to hydro	*				
	The resident's re	ecord lacked				
	documentation of	of the resident having any				
	adverse reaction	s to the administration of				
	During an interview with the West Unit Manager on 5/09/12 at 2:15 p.m., she indicated the physician was aware of the					
	allergy and still	wanted the hydrocodone				
	given. She indic	cated she had looked				
	through the resid	dent's chart and there was				
	not any docume	ntation related to the				
	_	es to the hydrocodone.				
	She indicated sh	e did not know when the				
		een notified of the allergy.				
		Manager indicated she had				
	•	armacy to inquire about				
		n. The pharmacy was				
	_	le any documentation. The				
		ated they had spoke with a				
	nurse on 4/6/12 for authorization and					
		r verbal authorization on				
	4/24/12.					
	2. Resident #138's record was reviewed					
		0 p.m. Resident #138's				
	_	ded, but were not limited				
	to, hypertension	, diabetes mellitus, and				

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155166		A. BUILDING					
155100			B. WIN			05/15/	2012
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE		
NAME OF THE PROPERTY OF THE PR				606 WA	LL ST RAISO, IN 46383		
				<u> </u>	RAISO, IN 40303		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	``			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAG		,		IAG			DATE
	congestive near	ianuic.					
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) congestive heart failure. Physician recapitulation orders for May 2012, indicated an order (originally ordered 3/17/12) for Lantus (insulin) inject 20 units subcutaneous daily at bedtime. A MAR (Medication Administration Record) for May 2012 lacked documentation the resident received the insulin. A Significant Change MDS (Minimum Data Set) Assessment, dated 3/22/12, indicated a the resident's cognitive status was intact. During an interview with SDC (Staff Development Coordinator) Nurse on 5/7/12 at 1:05 p.m., she indicated the insulin was not signed as given. During an interview with Resident #138, on 5/7/12 at 1:25 p.m., she indicated she gets her insulin at night. 3.1-50(a)(1) 3.1-50(a)(2)						
	3.1-30(α)(Δ)						

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